



PATIENT

White Tail Parsons

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

18.3 Pounds

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

**IMAGING
PERFORMED BY**

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

35827

DATE

2/23/22

PRESENTING CLINICAL SIGNS

Patient was diagnosed with a megacolon in early 2019, and has been managed on cisapride and miralax + OTC canned food diet ever since, with no significant episodes of constipation until 1 week ago, when she became anorexic and stopped having daily BMs. She was seen at ER on 2/16 with a functional bladder obstruction due to a fecolith in pelvic canal - bladder was manually expressed (hematuria, no U/A performed), she received enemas, and went home 2/17, switching from miralax to lactulose, starting high fiber diet, and stopping cisapride. She also received convenia for possible UTI. Since being home she has had regular, formed but soft BM's, but is still inappetent. Wt is down 0.9# from onset of signs on 2/15. On recheck rads today, colon is small with soft stool on rectal, but bladder still very large, with marked hematuria, rods and cocci on U/A, SpGr 1.031 (cystocentesis sample). CBC / Chem today - Creat of 1.6 (was 1.3 last month), otherwise unremarkable. Urine culture, GI panel pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.24 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.8 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.34 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.38 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.84 cm in height at the level of the hilus), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

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The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measured 0.31 cm. Jejunum wall measured 0.28 cm, 0.29 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

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The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

WEIGHT

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Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

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Kathleen Sennello DVM,
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- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. Fat deposition can occur in larger cats, creating a hyperechoic liver.
- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Today's scan is relatively normal. One concern would be possible detrusor muscle atony secondary to the urinary obstruction, which may have been somewhat chronic. In this situation, you should have a large, flaccid bladder that is easy to express. Other differentials could be a partial obstruction (stone or other), but none is visualized, or possibly a lower motor neuron bladder due to neurologic disease, which likely should be easy to express. In some cases of detrusor muscle atony, the urinary bladder must be emptied prior to treatment, or at least kept empty with expression while starting medications (Prazosin and Bethanechol), but prior to starting Bethanechol, an obstructive process needs to be ruled out (pass a urinary catheter/ensure a good urine stream, etc.).

REFERRING VET

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The cause for the current inappetence is unknown unless this has been bothering the cat for longer than we have identified, and there is early lipidotic change, etc. Correlate with bloodwork findings. I do not see any evidence of pancreatitis, but you could always consider a GI panel to further evaluate for this.

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Continue the stool softeners so as to ensure recurrent constipation is not a factor. I prefer Miralax, as it is much easier to administer and better tolerated, but the dose may need to be increased, and stool needs to be maintained at a pudding consistency. I would also consider restarting the Cisapride, as a



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second constipation episode would be difficult to deal with.

White Tail Parsons

No major mass effects were observed, so hopefully this is a matter of TLC and tweaking medications to achieve the best possible outcome. If things are not going well, consider secondary neurologic issues. Urinalysis and culture should be performed, and possibly even an abdominal CT scan to further evaluate the intrapelvic region. Additionally, a contrast cystogram could help to evaluate the bladder and urethra.

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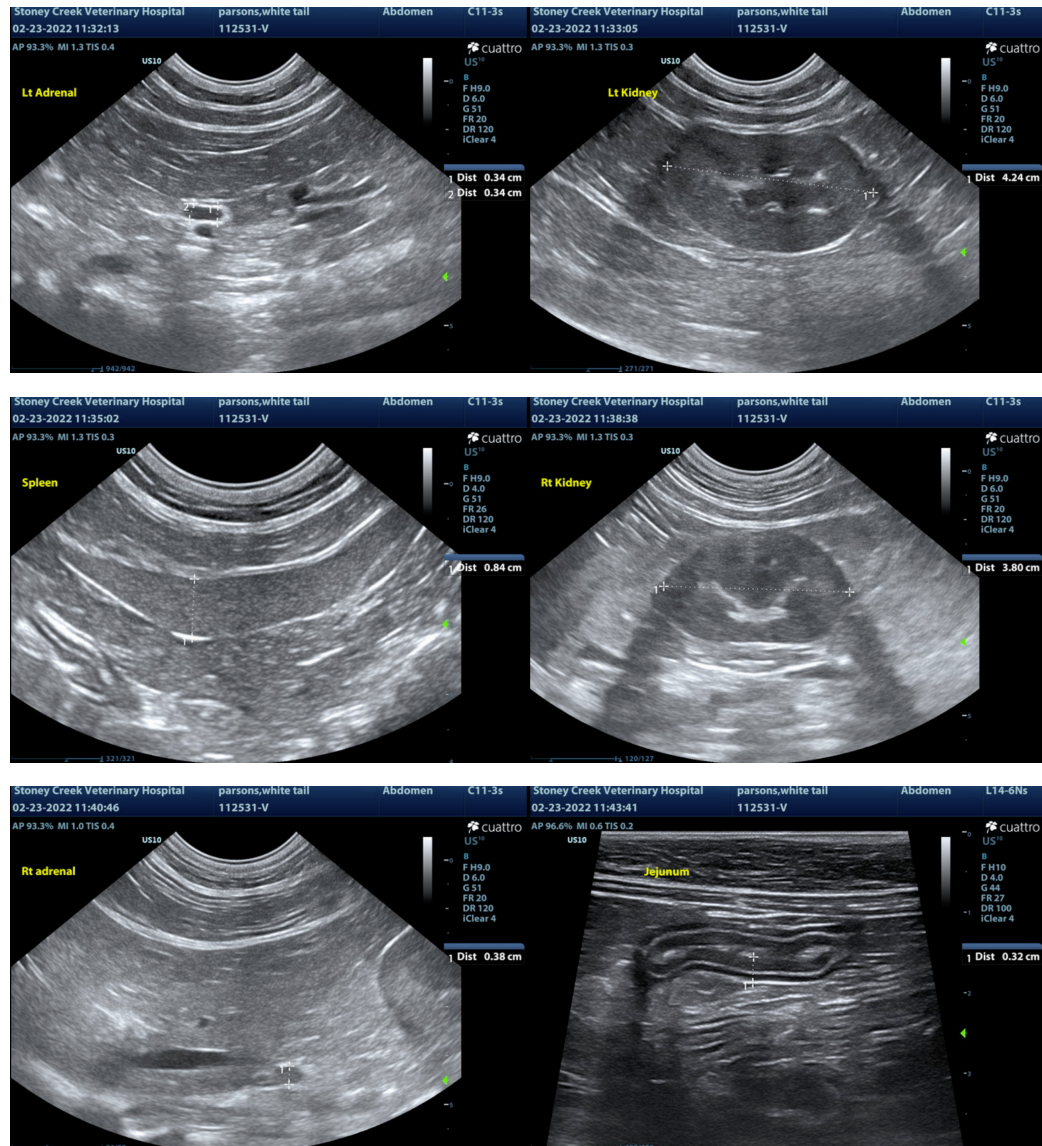
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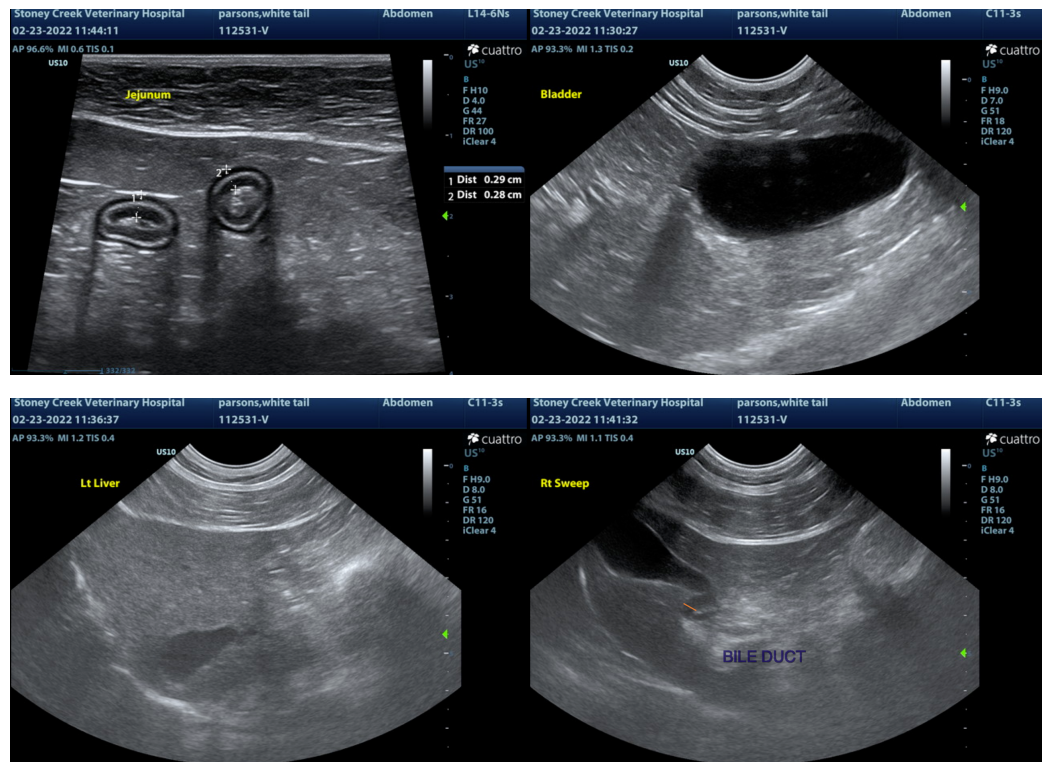
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

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